U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 03 November 2004

In the Matter of:
GERALD S. SMITH
Claimant

Case No.: 2002 BLA 5488

v.

MONTEREY COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances: Ms. Patricia Chasteen, Personal Representative
For the Claimant

Mr. L. Robert Mueller, Attorney
For the Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This matter involves a claim filed by Mr. Gerald S. Smith for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural History

First Claim

On October 23, 1981, Mr. Smith filed his first claim for black lung disability benefits under the Act. A representative for the District Director denied the claim on May 12, 1982 for failure to establish the presence of pneumoconiosis and total disability. A year later, the District Director received a letter from Mr. Smith indicating his disagreement with the denial of his claim

and requesting reconsideration. Since a year had passed since the denial of his claim by the time the District Director received his appeal, his correspondence was untimely as a modification request. Mr. Smith was advised that if he had experienced a change in condition he should consider filing another claim. (DX 1)[1]

Second Claim

On April 17, 1985, Mr. Smith filed his second claim for benefits. The District Director denied the claim on September 10, 1985 for failure to establish a material change in conditions, pneumoconiosis and total disability. After consideration of additional evidence, the District Director again denied the claim on October 18, 1985. On October 22, 1985, Mr. Smith appealed the denial of his claim and requested a hearing. On January 10, 1986, the District Director forwarded the claim to the Office of Administrative Law Judges ("OALJ"). After holding a hearing on March 31, 1987, Administrative Law Judge Samuel B. Groner denied benefits on March 4, 1988 because Mr. Smith did not establish a material change in condition or the presence of pneumoconiosis. Mr. Smith appealed the adverse decision. On January 29, 1990, the Benefits Review Board remanded the case to Judge Groner for re-evaluation of the medical opinion. On July 1, 1991, Judge Groner again denied the claim. Mr. Smith did not appeal. (DX 1)

Third, and Present, Claim

On September 1, 2001, Mr. Smith filed his third black lung disability benefits claim (DX 2). The District Director denied the claim on June 11, 2002 (DX 21) and Mr. Smith appealed on July 5, 2002 (DX 22). The case was forwarded to OALJ on September 9, 2002 (DX 26). After one continuance and pursuant to a revised notice of hearing, dated September 15, 2003, I conducted a hearing in Springfield, Illinois on October 28, 2003 with Mr. Smith, Ms. Chasteen, and Mr. Mueller present. My decision in this case is based on the hearing testimony and all the evidence admitted into the record: DX 1 to DX 26, EX 1, and EX 2.

ISSUES

1. Whether Mr. Smith in filing a subsequent claim on September 1, 2001 has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement, upon which the denial of his prior claim was based in July 1991.

2. If Mr. Smith establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

[1]The following notations appear in this decision to identify exhibits: DX – Director exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated to the following facts: a) Mr. Reynolds' length of coal mine employment was at least 21 years and Monterey Coal Company is the responsible operator in this case. (TR, pages 22 to 25).

Preliminary Findings

Born on September 24, 1919, Mr. Smith started mining coal in 1941 and continued through 1952. In 1952, he stopped coal mining and began working for a brick manufacturing firm for the next decade. Mr. Smith returned to coal mining in 1971 and retired in 1982. At the time of his retirement, Mr. Smith was struggling with shortness of breath and fatigue. In his last job as a coal miner, Mr. Smith was a utility man who hung tubing for ventilation, set timbers, and rock dusted. According to Mr. Smith the heaviest item he had to lift weighed ten pounds. He considered his physical labor as a utility man to be medium. (DX 1, DX 2, DX 3, DX 7 and DX 8, and TR, pages 38 to 40, and 46).

Since 1991, Mr. Smith's breathing problems have worsened to the extent that he can't walk more than two blocks without losing his breath. He can carry light grocery bags and still drives a car. Mr. Smith does not see any doctor for his breathing condition and is not taking any medication. Mr. Smith started smoking when he was 46 years old and continued through at least December 5, 2001.[2] When he smoked, Mr. Smith went through a pack a day. (DX 9 and TR, pages 40 to 45).

Issue #1 – Change in Applicable Condition of Entitlement

After the expiration of one year from the denial of benefits, the submission of additional material or another claim is considered a subsequent claim and adjudicated under the provisions of 20 C.F.R. § 725.309 (d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied ("applicable condition of entitlement") has changed and is now present. 20 C.F.R. § 725.309 (d) (3). If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. § 725.309 (d) (4). Consequently, the relevant inquiry in a subsequent claim is whether

[2]According to Dr. Drake, at the December 2001 pulmonary examination, Mr. Smith initially stated that he stopped smoking in the early 1980s. However, upon further questioning, Dr. Drake reported Mr. Smith admitted he had continued to smoke a pack a day until just before the examination. Dr. Drake also noted Dr. Billiter's May 2001 note that Mr. Smith was still a two pack a day cigarette smoker (DX 9). At the hearing, Mr. Smith testified that he stopped smoked in the early 1980s. When asked why Dr. Drake would report otherwise, Mr. Smith suggested the physician was "full of prunes" (TR, page 43). While Mr. Smith seemed to be a sincere witness, I note that Dr. Billiter and Dr. Mishkel found Mr. Smith to be a poor historian and most of the physicians to treat Mr. Smith in 2001 appear to believe that he was still smoking. In light of the evidentiary record, I have greater confidence in Dr. Drake's notations about Mr. Smith's cigarette smoking statement during the examination and find the assertion that Mr. Smith continued to smoke cigarettes in 2001 to be more reliable. Consequently, I conclude Mr. Smith continued smoking cigarettes at the rate of up to a pack a day through December 5, 2001.

evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In adjudicating a subsequent claim by a living miner in which the applicable conditions of entitlement relate to the miner's physical condition, I focus on the four basic conditions, or elements, a claimant must prove by preponderance of the evidence to receive black lung disability benefits under the Act. First, the miner must establish the presence of pneumoconiosis.[3] Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.[4] Third, the miner has to demonstrate he is totally disabled.[5] And fourth, the miner must prove the total disability is due to pneumoconiosis.[6]

With those four principle conditions of entitlement in mind, the next adjudication step requires the identification of the conditions of entitlement a claimant failed to prove in the prior claim. In that regard, of the four principle conditions of entitlement, the two elements that are usually capable of change are whether a miner has pneumoconiosis or whether he is totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element of entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

In Mr. Smith's case, in his last, prior claim, the District Director denied the claim for failure to establish pneumoconiosis or total disability. When Judge Groner adjudicated the claim, he stopped his analysis after finding Mr. Smith was unable to prove pneumoconiosis without addressing total disability. Under these procedural circumstances, I conclude Mr. Smith was able to prove neither pneumoconiosis nor total disability in his last prior claim. Consequently, for purposes of adjudicating the present subsequent claim, I will evaluate the evidence developed since the close of the record in 1987 to determine whether Mr. Smith can now prove the presence of pneumoconiosis or total disability.

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[3] 20 C.F.R. § 718.202.

[4] 20 C.F.R. § 718.203 (a).

[5] 20 C.F.R. § 718.204 (b).

[6] 20 C.F.R. § 718.204 (a).

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[7] The regulatory definitions include both clinical, or medical, pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[8] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201 (b). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. §718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),[9] and medical opinion (§ 718.202 (a)(4)). Since the record does not contain evidence that Mr. Smith has complicated pneumoconiosis,[10] and he filed his claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. In addition, he has not submitted a biopsy report and the record obviously does not contain an autopsy report. As a result, Mr. Smith will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis.

[7]20 C.F.R. § 718.201 (a).

[8]20 C.F.R. § 718.201 (a) (1) and (2).

[9]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

[10]Since the nodule found observed in radiographic images of the right lung is less than one centimeter (10 millimeters), it is not of sufficient size to be considered complicated pneumoconiosis.

Chest X-Rays

Date of x-ray	Exhibit	Physician	Interpretation
Jul. 23, 2001	DX 20	Dr. Long BCR[11]	Rounded 8 mm (millimeter) nodule right side, possible calcified granulomas; otherwise, no abnormal findings.
(same)	EX 2	Dr. Wichterman, BCR, B	Eight mm nodule, upper right lung; otherwise, clear.
Dec. 4, 2001	DX 12	Dr. Long, BCR	Completely negative.

Neither radiologist to examine the two recent chest x-rays has found evidence indicative of the presence of pneumoconiosis. Accordingly, the preponderance of the radiographic evidence is negative for pneumoconiosis and does not support a finding of pneumoconiosis under the provisions of 20 C.F.R. § 718.202 (a) (1).

Medical Opinion

Although Mr. Smith can not establish the presence of pneumoconiosis through chest x-ray evidence, he may still prove this requisite element of entitlement under 20 C.F.R. § 718.202 (a) (4) through the preponderance of the more probative medical opinion. To better evaluate the diverse medical opinion, a review of the other objective medical evidence in the record is helpful.

CT Scans

As part of a hospitalization evaluation, a CT scan with contrast of Mr. Smith's chest was accomplished on July 24, 2001. Dr. W. Ross Stevens noted "emphysematous changes throughout both lungs" and focal atelectasis or "airspace disease" in the right middle lung. The physician also identified an indeterminate 8 mm nodule in the right upper lung. Due to the nodule, Dr. Stevens recommended either a follow-up CT scan in a few months or comparison with prior films.

Dr. Wichterman also interpreted the July 24, 2001 CT scan. She also observed the indeterminate 8 mm nodule in the right upper lung; no other pulmonary nodules were observed. Dr. Wichterman also reported "few scattered emphysematous changes in both lungs."

[11]As I informed the parties at the hearing (TR, page 19), I take judicial notice of Dr. Long's board certification and have attached the board certification. The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may posses to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202 (a) (1) (ii).

Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV¹ pre[12] post[13]	FVC pre post	MVV pre post	% FEV¹ / FVC pre post	Qualified[14] pre Post	Comments
DX 11	Dec. 4, 2001 Dr. Drake	82 67"	1.59	2.34	24	67%	Yes[15]	Invalid per Dr. Tuetur

Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO^2 (rest) pCO^2 (exercise)	pO^2 (rest) pO^2 (exercise)	Qualified[16]	Comments
DX 20	Jul. 23, 2001 Dr. Mishkel	39.3	84.4	No[17]	(Obtained during hospitalization)
DX 10	Dec. 5, 2001 Dr. Drake	36	69	No[18]	

Dr. D. Ross Billiter
(DX 20)

On May 22, 2001, Mr. Smith presented to Dr. Billiter with continued severe back pain, which radiated down into his right leg. The physician noted that Mr. Smith may have stopped smoking cigarettes after his stroke. During the physical examination, Dr. Billiter heard decreased breath sounds, rhonchi and rales. His diagnosis included chronic obstructive pulmonary disease. Mr. Smith was hospitalized for relief of his pain symptoms.

On May 24, 2001, Dr. Billiter noted that Mr. Smith, who had mined coal for 26 years and was a heavy smoker, was a poor historian. Mr. Smith's medical history included a prior stroke and chronic obstructive pulmonary disease. Dr. Billiter advised Mr. Smith to stop smoking

[12]Test result before administration of a bronchodilator.

[13]Test result following administration of a bronchodilator.

[14]Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[15]The qualifying FEV1 number is 1.59 for 82 years old (the maximum age in the table is 71) and 67″; the corresponding qualifying FVC and MVV values are 2.12 and 65, respectively.

[16]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[17]For the pCO^2 of 39, the qualifying pO^2 is 61, or less.

[18]For the pCO^2 of 36, the qualifying pO^2 is 64, or less.

because he was smoking two packs of cigarettes a day. The physician also recommended a referral to a cardiologist.

Dr. Gregory J. Mishkel
(CX 20)

During a June 27, 2001 referral visit, Dr. Mishkel observed that Mr. Smith, a former coal miner, was a poor historian whose historical presentation was inconsistent with his prior documented medical history. During the evaluation, Dr. Billiter heard bilateral rhonchi and diagnosed chronic obstructive pulmonary disease. He suggested hospitalization to address angina.

Between July 23 and July 27, 2001, Mr. Smith was hospitalized and treated for stroke and heart-related problems. Dr. Mishkel reported that a chest x-ray was abnormal for a nodule and a subsequent CT scan had identified emphysematous changes in the lungs and a single focal 8 mm nodule. During the hospitalization, Dr. Mishkel diagnosed 80% stenosis of the right internal cartoid artery and performed selective left side coronary angiography on Mr. Smith's heart. Due to Mr. Smith's history of stroke, underlying coronary artery disease, Dr. Mishkel emphasized to Mr. Smith the importance of stopping his use of cigarettes.

Dr. Richard Embry
(DX 20)

On July 24, 2001, Dr. Embry evaluated Mr. Smith's right cartoid artery stenosis. Mr. Smith's medical history included severe chronic obstructive pulmonary disease, secondary to coal mine employment. His chest clear upon examination. Dr. Embry diagnosed coronary artery disease and cartoid disease. The next day, July 25, 2001, Dr. Embry performed a successful endartesectomy of the right cartoid artery in an effort to preclude an additional stroke.

Dr. William K. Drake
(DX 9)

On December 5, 2001, Dr. Drake, board certified in anatomic and clinical pathology,[19] conducted a pulmonary examination of Mr. Smith who reported chronic shortness of breath. At the same time, Dr. Drake observed that Mr. Smith was still able to work, clean his house, change the oil in his car, and fix his "rental houses." Mr. Smith had been a coal miner for more than 20 years. He was a utility man involved in coal extraction when he retired from coal mining. Mr. Smith was a pack a day cigarette smoker and started the habit in the early 1940s.

Upon physical examination, Dr. Drake heard a few wheezes. Although a chest x-ray from a 1985 pulmonary examination conducted by Dr. Drake had been positive for pneumoconiosis, the interpretation for the December 2001 chest x-ray was negative. The arterial blood gas study result was consistent with emphysema or asthma. Dr. Drake diagnosed chronic obstructive pulmonary disease ("COPD"), chronic bronchitis, and asthmatic bronchitis. Mr. Smith's pulmonary condition was due to his long history of heavy cigarette smoking. Although

[19]I take judicial notice of Dr. Drake's board certification and have attached the certification documentation.

Mr. Smith remained active, Dr. Drake concluded that he would "never be able to perform any kind of hard work" due to both COPD and generalized vascular disease.

Dr. Peter G. Tuteur
(EX 1 and EX 2)

On December 30, 2002, Dr. Tuteur, board certified in pulmonary disease and internal medicine, conducted a review of Mr. Smith's medical record. Mr. Smith had been a coal miner for 22 years and spent 16 years working for a brick manufacturer. Mr. Smith smoked cigarettes from 1943 into 2001, at the rate of one to two packs a day. In his later years, Mr. Smith's rate of cigarette use had diminished. His medical history included lumbar spinal stenosis, coronary artery disease and small strokes.

In regards to the medical information developed since 1991, Dr. Tuteur noted the most recent radiographic evidence was negative for pneumoconiosis. The recent CT scans only showed the presence of mild emphysema. Dr. Tuteur attributed the 8 mm nodule to The arterial blood gas studies were normal. The observed physical examination results wax and waned. Although some pulmonary function studies indicated obstructive abnormalities, the tests were invalid. Based on this medical evidence, Dr. Tuteur concluded Mr. Smith did not have coal workers' pneumoconiosis. Specifically, Dr. Tuteur found no "convincing evidence of coal workers' pneumoconiosis of sufficient severity or profusion to produce clinical symptoms." In particular, the varying nature of the physical examination findings, which at times were normal, did not display the "irreversibility of the interstitial disease." Additionally, the identified nodule was "almost certainly due to healed infectious granulomatous disease.

Dr. Tuteur found no valid "evidence of ventilatory failure or failure of gas exchange at rest, or during exercise." If the pulmonary function test had been valid, some evidence of an obstructive impairment may have been present. Dr. Tuteur "fully recognized that chronic inhalation of coal dust may produce airflow obstruction of this type, but the frequency with which it occurs is far less than the same condition due to chronic inhalation of tobacco smoke." As a result, Dr. Tuteur attributed any pulmonary defect to Mr. Smith's cigarette smoking.

Concerning disability, Mr. Smith was disabled from any work due to severe spinal stenosis, coronary artery disease, and cerebral vascular disease. In terms of a pulmonary impairment, regardless of etiology, Mr. Smith's respiratory condition was "of insufficient severity to produce clinical symptoms or physiologic impairment."

Discussion

Four of the five physicians, Dr. Mishkel, Dr. Embry, Dr. Drake, and Dr. Tuteur, who evaluated and/or treated Mr. Smith did <u>not</u> diagnose clinical pneumoconiosis. As Mr. Smith noted in his present claim application, the remaining physician, Dr. Billiter, had diagnosed the presence of coal workers' pneumoconiosis in 1985. However, in the present claim, Dr. Billiter did not include any reference to pneumoconiosis. Because the focus of Dr. Billiter's treatment in 2001 was Mr. Smith's back and leg pain, the absence of a pulmonary diagnosis is understandable. However, since I am only addressing medical opinions presented since 1987,

any previous diagnosis of pneumoconiosis by Dr. Billiter, in the absence of a present reaffirmation of that finding does not help Mr. Smith prove that he has developed pneumoconiosis since 1987. Additionally, Dr. Billiter's present silence on the issue, while understandable, precludes my determination whether he still believes Mr. Smith has pneumoconiosis in light of the most recent objective medical evidence.

Turning to the issue of legal pneumoconiosis, Dr. Billiter again provided no pulmonary diagnosis. To varying degrees, the other four doctors presented comments on the issue.

Due to a July 2001 CT scan, Dr. Mishkel was aware that Mr. Smith had emphysema. However, he did not identify the cause of the emphysema. Specifically, Dr. Mishkel did not associate Mr. Smith's coal mine employment as a contributing factor to his development of emphysema.

Based on his pulmonary examination, Dr. Drake identified three pulmonary problems for Mr. Smith: chronic obstructive pulmonary disease, chronic bronchitis, and asthmatic bronchitis. However, while aware of both pulmonary risks of coal dust and cigarette smoke for Mr. Smith, Dr. Drake did not believe coal dust caused his breathing problems. Instead, Dr. Drake identified only cigarette smoke as the cause of Mr. Smith's respiratory problems.

Likewise, after an extensive medical record review, Dr. Tuteur did not believe Mr. Smith's prolonged coal dust exposure caused the possible obstructive pulmonary defect. He agreed with Dr. Drake that the sole source of Mr. Smith's pulmonary problems was cigarette smoke.[20]

Dr. Embry stated that Mr. Smith had chronic obstructive pulmonary disease ("COPD"), secondary to his coal mine employment, which represents legal pneumoconiosis. However, considering the manner in which Dr. Embry presented the conclusion, it has little probative value. Mr. Smith presented to Dr. Embry in July 2001 for a cardiac assessment. As part of the evaluation, Dr. Embry simply reported COPD, secondary to coal mine employment, as part of Mr. Smith's medical history. In other words, Dr. Embry was simply reporting a prior determination. He did not actually render his own pulmonary diagnosis. Absent any other information about the source or foundation for that pulmonary history, Dr. Embry's historical notation of COPD due to coal mine employment is insufficient to prove the presence of legal pneumoconiosis.

In summary, none of the medical opinion establishes the presence of clinical pneumoconiosis. Likewise, the preponderance of the medical opinion is insufficiently probative to demonstrate that Mr. Smith has legal pneumoconiosis, a pulmonary problem due to his inhalation of coal dust.

[20]Had the evidentiary record contained a probative medical opinion of legal pneumoconiosis, the negative findings of Dr. Drake and Dr. Tuteur would have had reduced relative probative weight since neither physician seemed to consider whether both cigarette smoke and coal dust might have caused the obstructive impairment. Dr. Tuteur especially seemed to approach the causation issue as solely a choice between cigarette smoke and coal dust.

Total Disability

Another requisite element previously adjudicated against Mr. Smith was whether he suffered a totally disabling pulmonary impairment. To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

Mr. Smith has not presented evidence of cor pulmonale with right-sided congestive heart failure and again the record contains no evidence of complicated pneumoconiosis. As a result, Mr. Smith must demonstrate total respiratory, or pulmonary, disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

Pulmonary Function Tests[21]

Exhibit	**Date / Doctor**	**Age / Height**	**FEV¹ pre[22] post[23]**	**FVC pre post**	**MVV pre post**	**% FEV¹ / FVC pre post**	**Qualified[24] pre Post**	**Comments**
DX 11	Dec. 4, 2001 Dr. Drake	82 67"	1.59	2.34	24	67%	Yes[25]	Invalid per Dr. Tuetur

[21]To facilitate adjudication, I will repeat the summaries of the pulmonary function tests and arterial blood gas studies.

[22]Test result before administration of a bronchodilator.

[23]Test result following administration of a bronchodilator.

[24]Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[25]The qualifying FEV1 number is 1.59 for 82 (maximum age in the table is 71) and 67″; the corresponding qualifying FVC and MVV values are 2.12 and 65, respectively.

Under the provisions of 20 C.F.R. § 718.204 (b) (1), if the preponderance of the pulmonary function tests qualify under Appendix B of Section 718, then in the absence of evidence to the contrary, the pulmonary test evidence shall establish a miner's total disability. To apply this regulatory section requires a five step process. First, an administrative law judge must determine whether the tests conform to the pulmonary function test procedural requirements in 20 C.F.R. § 718.103. Second, the results are compared to the qualifying values for the various tests listed in Appendix B to determine whether the test qualifies. Third, an administrative law judge must evaluate any medical opinion that questions the validity of the test results. Fourth, a determination must be made whether the preponderance of the conforming and valid pulmonary function tests supports a finding of total disability under the regulation. Fifth, if the preponderance of conforming tests establishes total disability, an administrative law judge then reviews all the evidence of record and determines whether the record contains "contrary probative evidence." If there is contrary evidence, then it must be given appropriate evidentiary weight and a determination is made to see if it outweighs the pulmonary function tests that support a finding of total respiratory disability. *Fields v. Island Creek Coal Co*., 10 B.L.R. 1-19, 1-21 (1987).

With these principles in mind, I first note that the sole pulmonary function test conducted since the denial of Mr. Smith's last prior claim appears to conform to regulatory requirements and qualifies to show total disability under the regulations. Turning to the third step, two physicians reviewed the 2001 pulmonary test, Dr. Drake and Dr. Tuteur. Although Dr. Drake included the test results in his U.S. Department of Labor pulmonary evaluation report, he was silent as to whether the pulmonary function test was valid (DX 9). In contrast, Dr. Tuteur opined the 2001 pulmonary function study was "invalid as an assessment of maximum function" (EX 1). Dr. Tuteur's opinion is supported by an annotation on the pulmonary function test form which states: "unable to obtain 2 FEV_1 within 5% or 100 ml of each other" (DX 11). In light of the test annotations and Dr. Tuteur's uncontested conclusion, I find the December 4, 2001 pulmonary function test is invalid. Consequently, Mr. Smith is unable to establish total disability through pulmonary function tests under 20 C.F.R. § 718.204 (b)(2) (i).

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**pCO^2 (rest) pCO^2 (exercise)**	**pO^2 (rest) pO^2 (exercise)**	**Qualified**[26]	**Comments**
DX 20	Jul. 23, 2001 Dr. Mishkel	39.3	84.4	No[27]	(Obtained during hospitalization)
DX 10	Dec. 5, 2001 Dr. Drake	36	69	No[28]	

[26]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[27]For the pCO^2 of 39, the qualifying pO^2 is 61, or less.

[28]For the pCO^2 of 36, the qualifying pO^2 is 64, or less.

Since the sole arterial blood gas study did not meet the regulatory total disability criteria, Mr. Smith is also unable to establish total disability under 20 C.F.R. §§ 718.204 (b) (2) (iii).

Medical Opinion

Although Mr. Smith cannot establish that he is totally disabled based on the presence of complicated pneumoconiosis, cor pulmonale, pulmonary function tests or arterial blood gas studies, he may still prove this requisite element of entitlement under 20 C.F.R. §718.204 (b) (2) (iv) through the preponderance of the more probative medical opinion. Under this regulatory provision, total disability may be found through reasoned medical opinion:

> if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment as described in paragraph (b) (1) of this section.

As previously discussed, 20 C.F.R. §718.204(b)(1) defines such employment as either his usual coal mine work or other gainful employment requiring comparable skills. To evaluate total disability under these provisions, an administrative law judge must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of his respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993).

Based on Mr. Smith's claim forms and his hearing testimony, and considering his representation that he had to lift no more than ten pounds at a time, I find he engaged in moderate, or medium, manual labor in his last coal mine job as a utility man.

Having established the physical requirements of Mr. Smith's last coal mining job, I turn to the medical opinion in the present claim to assess whether he is totally disabled. In that regard, only Dr. Drake and Dr. Tuteur expressed an opinion on Mr. Smith's pulmonary capacity to return to coal mine employment.

Based on his pulmonary evaluation, which included a qualifying pulmonary function test, Dr. Drake concluded that Mr. Smith was unable to return to the hard work of a coal miner due to both his COPD and vascular disease.

Based on his review of the medical record, which included Dr. Drake's examination report, Dr. Tuteur disagreed. Dr. Tuteur determined Mr. Smith could not return to coal mining due to his back problems, coronary artery disease and cerebral vascular issues. At the same time, noting the December 2001 pulmonary function test was invalid, Dr. Tuteur found insufficient objective medical evidence to conclude that Mr. Smith's mild emphysema caused any physiological impairment.

Due to this dispute in medical opinion, I must first determine the relative probative value of the physicians' opinions in terms of documentation and reasoning. Regarding the first probative value consideration, documentation, a physician's medical opinion is likely to be more

comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter. Finally, in light of the extensive relationship a treating physician may have with a patient, the opinion of such a doctor may be given greater probative weight than the opinion of a non-treating physician. *See Downs v. Director, OWCP*, 152 F.3d 924 (9th Cir. 1998) and 20 C.F.R. §718.140 (d).

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

With these principles in mind, I conclude Dr. Drake's opinion on total disability has diminished probative value for both documentation and reasoning deficiencies. First, to the extent Dr. Drake relied on the December 2001 qualifying pulmonary function test to determine the severity of Mr. Smith's pulmonary obstruction, he relied on inaccurate information since the test was invalid. Second, and closely related, I am uncertain of the extent to which Dr. Drake relied on the pulmonary function test because he did not provide a reasoned explanation about his assessment of the extent of Mr. Smith's pulmonary impairment. Third, Dr. Drake's total disability conclusion is based on his determination that Mr. Smith's job as a coal miner involved "hard" work, which is inconsistent with my conclusion that Mr. Smith's level of effort was moderate. Dr. Drake did not express an opinion on whether Mr. Smith's pulmonary impairment would preclude moderate labor.

In comparison, Dr. Tuteur's assessment is better and more accurately documented. By reviewing the medical record, Dr. Tuteur based his opinion on more extensive documentation, which included the July 2001 CT scan finding of mild, scattered emphysema in both lungs. Also, because he believed the December 2001 pulmonary function test was invalid, Dr. Tuteur based his conclusion that Mr. Smith was not totally disabled from a pulmonary perspective on documentation that was more consistent with my determination on the invalidity of that pulmonary test. The probative value of Dr. Tuteur's opinion is further enhanced by his board certification in pulmonary disease. With his demonstrated expertise, Dr. Tuteur was in a better position to integrate all the objective medical evidence to determine the nature and extent of Mr. Smith's pulmonary condition.

In summary, due to documentation and reasoning shortfalls, Dr. Drake's opinion has less relative probative weight than Dr. Tuteur's better documented and qualified medical opinion. Accordingly, the preponderance of the more probative medical opinion demonstrates that Mr. Smith does not suffer a totally disabling pulmonary condition. As a result, Mr. Smith is unable to prove total disability through medical opinion under 20 C.F.R. §718.204 (b) (2) (iv).

CONCLUSION

Neither the preponderance of the radiographic evidence nor the more probative medical opinion establish the presence of coal workers' pneumoconiosis in Mr. Smith's lungs. Likewise, none of the valid pulmonary tests or the preponderance of the more probative medical opinion establish that Mr. Smith is totally disabled due to a pulmonary impairment. As a result, Mr. Smith is unable to establish a requisite condition of entitlement under the Act previously adjudicated against him. Accordingly, under 20 C.F.R. § 725.309 (d) (3), his subsequent claim for black lung disability benefits must be denied.

ORDER

The claim of MR. GERALD S. SMITH for benefits under the Act is **DENIED**.

SO ORDERED:

A

Richard T. Stansell-Gamm
Administrative Law Judge

Date Signed: November 1, 2004
Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. § 725.478 and § 725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.

Attachment No. 1

American Board of Medical Specialties
Certification:

Scott D. Long, MD

Certified by the American Board of Radiology in:

Diagnostic Radiology

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Attachment No. 2

American Board of Medical Specialties
Certification:

William K. Drake, MD

Certified by the American Board of Pathology in:

Anatomic Pathology and Clinical Pathology

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